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Chapter 16: Insurance

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CHAPTER 16

Insurance

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A. COURT DECISIONS

§16.1. Physical damage insurance: Construction of policy. During the 1962 SURVEY year an unusual number of cases requiring construction of particular policy terms came before the Supreme Judicial Court. Three such cases involved various types of physical damage policies. In the first of these, *Sherman v. Employers' Liability Assurance Corp.*,[1] the plaintiff insured sought to bring within the protection of a fire insurance policy covering property of the insured's laundry and cleaning customers while in the insured's premises, in the custody of the insured's collecting agencies or branch stores, or "in transit," a loss to property of the insured's customers caused by fire in the premises of an independent laundering company. The insured was in the business of collecting laundry and cleaning at its customers' homes and assembling, marking and checking the items at its premises, where they were picked up in bulk by the laundering company and taken to its premises for washing and cleaning. When this work was completed the goods were returned in bulk by the laundering company to the insured's premises, where they were sorted and redelivered by the insured to its customers.

Excepting to the direction of a verdict for the defendant insurer, the insured argued that the case should have gone to the jury, which could have found that the goods at the time of their destruction were in the custody of its collecting agencies or, alternatively, "in transit." The Court found no ambiguity which would require the language of the policy to be construed against the insurer.[2] The goods were not in charge of a collecting agency, but in the hands of an independent contractor under a contractual obligation to the insured to clean or launder them. In these circumstances it cannot be said that the goods were "in transit" or that their presence on the premises of the laundering company was a part of or incident to transportation.[3] To hold

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§16.1. [1] 343 Mass. 354, 178 N.E.2d 864 (1961).

[2] August A. Busch & Co. of Massachusetts v. Liberty Mutual Insurance Co., 339 Mass. 239, 158 N.E.2d 351 (1959), discussed in 1959 Ann. Surv. Mass. Law §16.1.

[3] The various meanings of "in transit" are discussed in Koshland v. Columbia Insurance Co., 237 Mass. 467, 472-477, 130 N.E. 41, 43-45 (1921).

otherwise, in the opinion of the Court, would render meaningless the words of the policy designed to extend coverage to property while on the insured's premises or in movement under the insured's control between such premises and the customer.

In *Schroeder v. Federal Insurance Co.*[4] the insurer sought to deny coverage under a policy of aircraft insurance for loss of a Beech Bonanza G-35 airplane owned by the insured, relying on a policy declaration that "[t]he aircraft will be operated only by . . . [the insured] and/or any duly certificated private pilot or better who has at least 250 hours total flying time 25 hours of which have been in a Beech Model 35 aircraft." A condition of the policy required the production of logbooks, kept as required by the Civil Aeronautics Board, in support of claims made under the policy. A further condition specifically defined the word "flight" as used in the schedule of coverage. The question stipulated by the parties to the action was whether the pilot operating the airplane at the time of the accident had the requisite number of hours of flying time as set forth in the policy.

One of the pilot's logbooks had disappeared and another was destroyed by one of his infant children, but the trial judge after preliminary findings ruled that secondary evidence could be introduced to prove the contents of the unavailable logbooks. In affirming the denial of a directed verdict for the insurer, the Supreme Judicial Court found that the production of logbooks (at the request of the insurer) was a condition precedent to recovery under the policy, but that this policy provision did not preclude proof of "flying time" by evidence other than the contents of logbooks. If only this special method of proof of flying time was to be permitted, the condition should have been expressly made applicable to the provision limiting operation of the aircraft to pilots with stated hours of flying experience. The Court also rejected the view that the words "flying time" as used in this provision were the equivalent of the term "flight" as defined in relevant federal regulations and used in the policy to express the coverage afforded.

The third case, *Joseph E. Bennett Co. v. Fireman's Fund Insurance Co.*,[5] involved various policies of fire insurance, each of which afforded extended coverage including coverage for loss by malicious mischief and vandalism. The policies provided: "When this policy covers buildings, it shall cover the basic structure and additions, including foundations . . . and . . . shall include building service equipment . . . and all property fastened to and made a part of the building." The policy further provided that permission is "granted to make additions, alterations and repairs to the building or structure described; and this policy . . . shall also cover such additions, alterations or repairs when not otherwise covered by insurance."

The policies as written specifically covered a clubhouse, pro shop

[4] 343 Mass. 472, 179 N.E.2d 328 (1962).
[5] 1962 Mass. Adv. Sh. 505, 181 N.E.2d 557.

and two pump houses belonging to a country club. Subsequent to the issuance of some of the policies the clubhouse was reconstructed and the property was further improved by the construction of a swimming pool set in a concrete terrace in the rear of the clubhouse and connected to the clubhouse by twelve to fifteen steps and a second concrete terrace extending the width of the building and thirty feet out from it. None of the policies purport to describe the swimming pool as property covered. The plaintiff sought to recover for very serious vandalism damage to the swimming pool, urging that the pool was an "addition" to the clubhouse within the alterations and repairs clauses of the policies. The Supreme Judicial Court took note of the requirement that ambiguous policy terms must be construed against the insurer, but found that the "term 'addition' most aptly describes an enlargement of what previously existed by a piece of construction of the same general character, having some definite connection and community of use with the basic building," and that the swimming pool was not such an addition. While a country club swimming pool may be said to be a structure, the usual "additions" clause of a fire insurance policy applies only to buildings and not to adjacent facilities which are not buildings.

§16.2. Disability insurance: Construction of policy. Two additional cases requiring the construction of policy language involved disability insurance. The plaintiff in *MacArthur v. Massachusetts Hospital Service, Inc.*[1] sought a declaration as to his right to payment for hospital expenses under the terms of his "subscriber certificate" issued by the defendant "Blue Cross." The plaintiff was a municipal fireman who suffered personal injuries, resulting in hospital confinement, while performing his duties at a fire under the direction of the chief of the fire department. The subscriber's certificate recited: "No credits shall be provided for services, care, or treatment for personal injuries or illness arising out of or in the course of employment or incurred in the line of duty, or for admissions to a hospital operated by any agency of the United States Government, or for any other services, when the member would be entitled to full or partial benefits under any municipal, State, or Federal law, regulation, or agency, if this contract were not in effect." The Supreme Judicial Court rejected the defendant's contentions that the plaintiff was not entitled to benefit payments because (1) he was injured in the line of duty, and (2) he was entitled to full or partial benefits under state law.[2]

In order to bring the plaintiff's claim within the coverage the Court was constrained to read the quoted contractual provisions as though the words "when the member would be entitled to full or partial bene-

§16.2. [1] 343 Mass. 670, 180 N.E.2d 449 (1962).

[2] General Laws, c. 41, §100, provides in part that a city "shall indemnify a . . . fireman or a member of the fire department . . . to an amount not more than the amount recommended by the board or officer authorized to appoint . . . firemen or members of the fire department of such city . . . for expenses or damages sustained by him while acting as a . . . fireman. . . ."

fits under any municipal, State, or Federal law, regulation, or agency, if this contract were not in effect" related to each of the series of clauses preceding it. This reading is made possible by adverting to the comma appearing before the word "when," by inference suggesting that the absence of the punctuation mark would have required the opposite construction. Giving such weight to a punctuation mark overcomes the well-established rule that in successive clauses a disjunctive phrase of the last clause is not generally effective beyond its nearest antecedent.[3]

Thus read the contract provision is said to deny benefits for injury suffered "in line of duty" if the injured person is "entitled to full or partial benefits" under state law. The benefits under state law, if any, to which the plaintiff may be entitled are those under G.L., c. 41, §100.[4] It has been held that the obligation of the city under this statute is to indemnify the claimant to an amount not in excess of that recommended by the appointing officer and that nothing in the statute requires the appointing officer to make any recommendation. In the opinion of the Court the word "entitled" must be construed to mean that the injured person has a claim of right. Under the doctrine of the *Fortin* case[5] the plaintiff in this case has no claim of right to indemnification from the city.

By this circuitous route the Court was able to make a contract, which is intended to afford benefits for "non-occupational" injuries or illness, also afford benefits for an "occupational" injury. While it asserted that there is no doubt as to the meaning of the section in question, it nevertheless relied upon the doctrine that ambiguous language in a policy must be resolved in favor of the insured. Moreover, it asserted that, consistent with this principle, exclusionary language in a policy must be strictly construed so as not "to diminish the protection purchased by the plaintiff," although there was no showing that the plaintiff purchased or thought he purchased anything more than the coverage grant for which the defendant argued. An interesting question would be presented if a similarly circumstanced plaintiff without any claim of right had nevertheless been indemnified by his municipal employer. As with so many cases of this kind it is difficult to see any other objective than to find a way to bring an unindemnified loss within the coverage of an insurance policy.

In *Dowdall v. Commercial Travelers Mutual Accident Assn. of America,*[6] the plaintiff sought to recover disability benefits under a

[3] Cushing v. Worrick, 9 Gray 382 (Mass. 1857); Perry v. J. L. Mott Iron Works Co., 207 Mass. 501, 93 N.E. 798 (1911). Note also Greenough v. Phoenix Insurance Co., 206 Mass. 247, 92 N.E. 447 (1910), in which a comma was used to support a construction that a qualifying clause modifies a more remote antecedent than the nearest, and Dowling v. Board of Assessors of Boston, 268 Mass. 480, 168 N.E. 73 (1929), holding that the punctuation mark will not be allowed to produce a result which is inconsistent with the obvious purpose of the statutory language there in question as shown by the legislative history of the enactment.

[4] Quoted in part in note 2 *supra.*

[5] Fortin v. Mayor of Chicopee, 325 Mass. 214, 89 N.E.2d 760 (1950).

[6] 1962 Mass. Adv. Sh. 477, 181 N.E.2d 594.

certificate issued by the defendant insurer which stated that benefits were payable only for disability "resulting from sickness or disease originating more than 30 days . . . after the effective date hereof." The certificate was issued on November 10, 1952, and apparently was issued to replace a certificate issued some twenty-one years earlier and had attached to it photostatic copies of the applications for both certificates. The benefits afforded by the replacement certificate were double those afforded by the replaced certificate. The plaintiff's disability was caused by multiple sclerosis, which originated subsequent to the effective date of the earlier certificate but prior to the effective date of the replacement certificate, but did not become known to the plaintiff until after the latter date.

Knowledge of the existence of a disease on the part of the plaintiff is not required; it is enough that the disease had originated prior to the effective date of the certificate currently in force. The plaintiff was not entitled to recover under this certificate. Moreover, the plaintiff could not sustain the position that he should recover the benefits of the earlier certificate on the basis that the second certificate simply increased the benefits previously afforded. This conclusion seems inescapable in face of the provision reciting: "This certificate is issued in lieu of and supersedes all prior certificates issued by this Association to the member herein named, and this Association shall not after date hereof be liable for any loss or claim of any kind arising hereafter under or by reason of any certificate heretofore issued by it to said member." While a contract could be drawn to give the effect for which the plaintiff contended, unhappily this certificate was not so drawn.

§16.3. Theft insurance: Locked car warranty. The plaintiff in *Tumblin v. American Insurance Co.*[1] had insured against fire and certain other perils tools and equipment stored in a utility trailer parked on certain land not owned by the plaintiff but adjacent to premises owned by him. This policy subsequent to its issuance was endorsed to cover the insured property against loss caused by the peril of theft. The policy was further endorsed to incorporate in it the "locked car warranty."[2] Thereafter the plaintiff's trailer was stolen. In order to bring his loss within the coverage of the policy, the plaintiff had to prove that the loss occurred by reason of "violent forcible entry." It was not enough to show the theft of the trailer because the policy did not purport to cover the loss of contents through theft of the trailer. Nor did it help the plaintiff to assert the likelihood that the thief would break into the trailer to obtain the contents. To recover he must prove that the loss was within the description of the risks covered.

§16.4. Crime insurance: Dishonesty of employees. *Liberty Mutual*

§16.3. [1] 1962 Mass. Adv. Sh. 755, 182 N.E.2d 306.

[2] This provision recites that "This policy covers against theft from unattended vehicle only when directly resulting from violent forcible entry into vehicles equipped with bodies of entirely closed construction, provided the doors and other openings of such vehicles were closed and locked when the forcible entry and theft occurred."

Insurance Co. v. A. C. Martinelli Rogers Plastic Corp.[1] was a bill in equity to determine the rights and liabilities among all of the parties arising out of allegations that certain checks were fraudulently diverted by an employee of defendant Rogers, to whom the plaintiff insurer had issued a crime policy affording coverage against the "dishonest or fraudulent" acts of its employees. There was testimony that Rogers had agreed to make loans from time to time to Ayer Chemicals, Inc., and did so through its employee by transferring to Ayer checks received by it from its customers. Ayer never repaid any of these loans and subsequently transferred all of its assets to defendant Puritan Chemical Corporation. Puritan did not assume Ayer's debts. On the vital facts this testimony was completely contrary to that presented on behalf of Rogers. The Supreme Judicial Court, holding that it was required to decide the case upon its own evaluation of the testimony, giving due weight to the findings of the trial judge, affirmed the decree of the Superior Court that the transferred checks were in fact loans and the insurer had no liability to Rogers under its policy. As between the parties, the only claim is that of Ayer for the repayment to Rogers of its indebtedness with interest.

§16.5. Motor vehicle insurance: Board of appeal. With the enactment of the Compulsory Motor Vehicle Liability Insurance Law[1] the legislature created in the Department of Banking and Insurance a board of appeals on motor vehicle liability policies and bonds to hear, among other things, appeals from the actions of insurance companies in canceling or refusing to issue such policies or bonds. This board is made up of the Commissioner of Insurance and the Registrar of Motor Vehicles, or designated representatives, and an assistant attorney general.[2] In *Cieri v. Commissioner of Insurance*,[3] the petitioner, the designee to the board of appeals of a Commissioner of Insurance whose term of office had expired, sought to retain his position and contended that he could be involuntarily removed, by virtue of the Veterans' Tenure Act,[4] only in accordance with the method prescribed by the civil service laws.[5] The Supreme Judicial Court in disposing of this contention held that the petitioner's right to hold the office in question and to exercise its powers depended wholly upon the appointive power of the Commissioner of Insurance, who is powerless to give the appointee a tenure of office beyond his own. The Court held further that the time during which the appointee held over into the term of the successor commissioner, by whom he was not reappointed, could not, in any event, be counted in satisfying the three years in office required by the Veterans' Tenure Act to entitle the petitioner to a hearing before he can be involuntarily removed.

§16.4. 1 1962 Mass. Adv. Sh. 967, 183 N.E.2d 106.

§16.5. 1 G.L., c. 90, §§1A, 34A-34I, added by Acts of 1925, c. 346.
2 Id., c. 26, §8A, added by Acts of 1925, c. 346, §3.
3 343 Mass. 181, 178 N.E.2d 77 (1961).
4 G.L., c. 30, §9A.
5 Id., c. 31, §§43, 45.

Having disposed of the case on these grounds, the Court was at pains to observe that the position of representative of the Commissioner of Insurance is not, as a matter of legislative intent, within the sweep of the Veterans' Tenure Act. The membership of the board of appeals consists of the Commissioner of Insurance, the Registrar of Motor Vehicles and an assistant attorney general. The first two of these officers may act vicariously through designees, whose designation is clearly revocable. The Commissioner of Insurance, or his designated representative, is by the statute made chairman of the board, and the board itself serves in the Division of Insurance. In the view of the Court, the requirements of the statute evidence a legislative intention to make the designation of a representative a personal prerogative of the commissioner with the expectation that the representative would serve at the pleasure of the commissioner and reflect his policies in the highly sensitive area of cancellations by insurance companies of the insurance required as a condition of maintaining a motor vehicle registration. It does not appear that the legislature could have intended the Veterans' Tenure Act to negate the provisions of the prior enactment.

§16.6. Motor vehicle insurance: Definition of insured. *Nichols & Co. v. Travelers Insurance Co.*[1] was a bill for a declaratory decree that the plaintiff Nichols was an omnibus insured under the non-statutory bodily injury liability coverage of a Massachusetts motor vehicle liability policy issued by Travelers to one Barron. Judgment in a tort action had been had against both Nichols and Barron for injury sustained by a woman struck by a bag of wool tossed to the ground from a truck owned by Barron to be picked up by one of the employees of Nichols, who was assisting in the unloading of the truck, and carried into the premises of Nichols. Nichols was insured under a comprehensive general liability policy issued by the Century Indemnity Company covering the premises, but sought to be indemnified under the motor vehicle policy, which contained the standard language reciting that commercial use of the motor vehicle "includes the loading and unloading thereof."

The motor vehicle policy in question apparently was in the form used for a number of years in the early fifties which defined insured under Coverage B, the non-statutory bodily injury liability coverage, in the same terms as for Coverage A, the statutory coverage, i.e., "the unqualified word 'insured' includes the named insured and also includes any other person responsible for the operation of the motor vehicle with the express or implied consent of the named insured." This provision has since been amended, and the definition of "insured" for the non-statutory coverage of the Massachusettts motor vehicle liability policy is now expressed in the language of the Standard Provisions for Automobile Liability Policies.[2]

Following its earlier decision in *O'Roak v. Lloyds Casualty Co.*,[3] in

§16.6. [1] 343 Mass. 494, 179 N.E.2d 593 (1962).
[2] See note on Standard Provisions Program, 1961 Ann. Surv. Mass. Law §14.15.
[3] 285 Mass. 532, 189 N.E. 571 (1934).

which it was held that the words "express or implied consent" primarily modify not the word "operation" but the word "responsible," and thus that responsibility for operation of the motor vehicle together with possession conferred by the owner and not whether the particular operation was with the express or implied consent of the owner is the proper test, the Supreme Judicial Court denied plaintiff's petition. The plaintiff's employees never had possession of the motor vehicle nor any control of it, even though they participated in the process of unloading. They were not therefore responsible for the operation of the motor vehicle and could not become insureds under the motor vehicle liability policy.

§16.7. Medical service corporation: Surgical fee schedule. In *Massachusetts Medical Service v. Commissioner of Insurance,*[1] the medical service corporation, commonly called the Blue Shield, and a participating surgeon appealed a final decree in the Superior Court dismissing a petition to revise an order of the Commissioner of Insurance disapproving a filing of increased fees to the physicians for surgical services to "Plan B" subscribers, certain increased benefits to subscribers, and increased subscription fees. There was no question that subscription fees would have to be increased if the surgical fee schedule was increased. At issue was the proposed increase in the surgical fees to be paid to participating physicians. The Superior Court judge found that there was substantial evidence to support the commissioner's order.

Every subscription certificate of the Blue Shield, whether individual or group, together with the rates charged therefor must be filed with the Commissioner of Insurance.[2] Individual certificates may not be used without his prior approval; group certificates must be filed within

§16.7. 1 1962 Mass. Adv. Sh. 777, 182 N.E.2d 298, also noted in §12.13 *supra.*

2 General Laws, c. 176A, §4, provides in part as follows: "Any medical service corporation may enter into contracts with its subscribers and with participating physicians . . . for such medical and surgical services as may lawfully be rendered by them to the subscribers and their dependents, and may pay for such services. The form of agreement with participating physicians . . . and the rates at which participating physicians . . . are compensated for their services . . . shall at all times be subject to the written approval of the commissioner.

"Any agreement between a medical service corporation and a person . . . shall be considered a non-group medical service agreement. Under such an agreement the form of the subscription certificate and the rates charged . . . to the subscribers shall be filed with and receive the prior approval of the commissioner. No such agreement shall be approved if he finds that the benefits provided therein are unreasonable in relation to the rate charged, nor if the rates charged are excessive, inadequate or unfairly discriminatory.

"Any agreement between a medical service corporation and a group of five or more persons or with the employer, employers or other representatives of such group . . . shall be considered a group medical service agreement.

"Under such a group medical service agreement, subscription certificates and rates charged . . . to the subscribers shall be filed with the commissioner within thirty days after their effective date, and shall be subject to subsequent disapproval by the commissioner if he finds that the benefits provided therein are unreasonable in relation to the rates charged, or the rates charged are excessive, inadequate or unfairly discriminatory."

thirty days after their effective date and are subject to his subsequent disapproval. In either case, certificates must be disapproved if the benefits provided are unreasonable in relation to the rate charged, or if the rates charged are excessive, inadequate or unfairly discriminatory. This test combines that fixed by the statute for individual accident and sickness policies issued by insurance companies generally and the rate approval criteria established under the Casualty and Surety Rate Regulatory Law.[3]

Likewise, every agreement with participating physicians and the rates at which they are to be compensated for their services are made subject to the approval of the Commissioner of Insurance.[4] No explicit reference is made in the statute to the standards to be applied by the commissioner in approving or disapproving the fee schedules. But the Supreme Judicial Court encountered no difficulty in concluding that the essential interrelationship between the charges to subscribers and the compensating fees to participating physicians implicitly required that the same standards be applied to both. Thus the fee schedule may be disapproved only if the fees are inadequate, excessive or unfairly discriminatory.

The rate-regulating function is an administrative one, to which a hearing is appropriate. The commissioner in making his determination must apply criteria that are relevant to the purpose and effect of the statute. It is of scant relevance to show that many individuals will be affected, that insurance costs will increase for many municipalities and many private employers, that the cost of commercial insurance plans may be influenced or that the earnings of physicians are already relatively high. Prevailing charges for similar services in the community, physicians' fees in uninsured cases, increases in physicians' expenses since the adoption of existing fee schedules, increases in the cost of living indices and studies of the Blue Shield fee committee are all relevant.

Inasmuch as the Commissioner of Insurance insisted that the only statutory limitation upon his disapproval is that it be in the public interest, the Court refused to search the record for testimony which, if given weight, would support the commissioner's adverse decision. The proceedings were remanded to the commissioner with instructions to review the filing on the basis of the standards prescribed in the Court's opinion.

§16.8. Policy conditions: Assistance and cooperation. *Rose v.*

[3] General Laws, c. 175, §108, subsection 8A, provides in part as follows: "The commissioner may, within thirty days after the filing of a copy or form of such a policy [of accident and sickness insurance], disapprove such form of policy if the benefits provided therein are unreasonable in relation to the premium charged, or if it contains any provision which is unjust, unfair, inequitable, misleading or deceptive, or which encourages misrepresentation as to such policy."

General Laws, c. 175A, §5(a), the Casualty and Surety Rate Regulatory Law, requires that: "All rates shall be made in accordance with the following provisions: . . . 4. Rates shall not be excessive, inadequate or unfairly discriminatory."

[4] See note 2 *supra*.

Regan[1] was a bill in equity to reach and apply the obligation of Regan's insurer, the defendant American Employer's Insurance Company, under the non-compulsory guest coverage of a motor vehicle liability policy in satisfaction of separate judgments obtained by three individual claimants. The defendant insurer denied liability on the ground that the insured had breached the notice and the assistance and cooperation clauses of the policy. The defendant insured duly notified the insurer of the accident, but thereafter moved and gave no notice of change of address to the insurer. Unsuccessful efforts were made to serve the insured with writs in the three actions; in two of these he was subsequently defaulted for failure to appear and answer. The insurer learned of these defaults from the claimants' attorney, who had indicated a willingness to have the defaults removed. The insurer thereupon, without any disclaimer or reservation of rights and without making any effort to contact the insured, entered on his behalf a general appearance, filed answers, had the defaults removed and generally assumed control of the proceedings. In the view of the Supreme Judicial Court there was a material breach of the policy conditions by the insured, but the insurer may not take advantage of this breach because its general appearance made a significant and irrevocable change in the insured's position, giving the trial court a basis for jurisdiction. As with an insurer seeking to disclaim after having defended without any reservation of rights or disclaimer of liability, it would be unfair to permit the insurer to withdraw protection after its participation in the action had irrevocably and materially affected the insured's position without his knowledge or consent. Moreover, it is immaterial that the insured in all likelihood, upon notice prior to removal of default, would have authorized the general appearance in his behalf notwithstanding a disclaimer by the insurance company.

B. Legislation

§16.9. Fire insurance. During the 1961 session of the General Court the Division of Insurance was directed by the legislature to make a study relative to the difficulty encountered by certain property owners in securing fire insurance, and the need for the creation of an assigned risk plan to assist such persons as are unable to obtain such insurance.[1] Late in December of 1961 the division filed a preliminary report and obtained additional time to complete its study and, in particular, to enable it to appraise the effectiveness of a voluntary All-Industry Inspection Program developed by the insurance companies and to evaluate schedule rating plans for substandard dwellings recently approved for use in Missouri and Ohio.[2] As in the city of Boston and other urban centers throughout the country, the larger

§16.8. [1] 1962 Mass. Adv. Sh. 647, 181 N.E.2d 796.

§16.9. [1] Resolves of 1961, c. 114, discussed in 1961 Ann. Surv. Mass. Law §14.8.
[2] Resolves of 1962, c. 31.

cities of these two states have developed blighted areas with marginal, substandard and, in some cases, totally uninsurable properties.

Understandably, the owners of marginal or substandard properties find it difficult to obtain insurance at manual rates, a difficulty sought to be overcome in Missouri and Ohio by the adoption of schedule rating plans which provide for substantial premium surcharges for deficiencies in heating systems, electric wiring, maintenance and the like. In Boston the companies undertook to evolve a solution to the same problem by voluntarily adopting a self-imposed obligation to make a physical inspection of any property before declining to insure such property and, if the property was found to be substandard, to make available to the owner in specific detail what must be done to the property to make it insurable. To implement this plan an inspection office has been established which makes immediately available to the companies, to insurance agents and brokers, and to property owners competent inspection service and objective evaluations of the deficiencies which inhibit the extension of fire insurance coverage.

In its final report the Division of Insurance recommended against the enactment of assigned risk plan legislation. From its studies it was concluded that the availability of schedule rating for fire insurance on substandard dwellings had resulted in the writing of a very limited amount of such insurance. Basically, the solution to the problem lies not in compelling the availability of insurance, but in strict enforcement of building laws, more rigid adherence to fire prevention and public safety codes, and vigorous promotion of urban redevelopment and rehabilitation programs. Meanwhile, the All-Industry Inspection Program has been singularly successful in making a very substantial volume of insurance available at manual rates in areas characterized by many marginal properties and high frequency of fire loss. This success is reflected, as noted in the division report, in (1) a substantial increase in the number of property inspections, (2) a constant decline in the rate of refusals to insure, (3) a material increase in the number of requests for reinspection of properties previously rejected for deficiencies which have been removed, (4) a continuing decline in the number of requests for approval of excess rates by the division,[3] and (5) a corresponding increase in the number of requests to withdraw excess rates.

The legislature accepted the findings of the Division of Insurance, and the bill to create an assigned risk plan failed of enactment.

§16.10. Fire insurance: Nuclear energy. During the 1962 SURVEY year the insurance companies finally succeeded in persuading the legislature to enact a statute to clarify the application of the standard fire policy[1] to loss caused by nuclear reaction, nuclear radiation and radio-

[3] See 1961 Ann. Surv. Mass. Law §14.8, note 1.

§16.10. [1] General Laws, c. 175, §99, prescribes the language of the so-called Massachusetts Standard Fire Policy, which must be used verbatim by all insurance companies to insure against loss by fire or by fire and lightning to property situated within the state.

active contamination. The standard policy contains no definition of "fire," and the statute permits no editorial additions or modifications to the required policy language. The absence of any such definition raised serious questions concerning the construction which a court might give to the policy if faced with the necessity of determining whether a nuclear reaction generating a release of energy resulting in a blast accompanied by enormous heat and blinding light involved the essential elements of a fire as that term is used in the statute. Could it be said that damage done by nuclear radiation or radioactive contamination was damage "by fire"? Could it be said that the statutory fire policy covers loss caused by nuclear radiation or radioactive particles released by an atomic reactor as a result of, or accompanied by, a fire in the reactor? An affirmative answer to these questions would cast doubt upon the ability of private insurers to pay the potential losses under such policies or even to offer coverage at a rate which a typical property owner could pay. It has been estimated that a major nuclear incident resulting in radioactive contamination of a congested metropolitan area could produce losses in excess of the aggregate surplus of all fire insurance companies in the United States.

Acts of 1962, c. 418,[2] enacts with one amendment the uniform bill approved by the National Association of Insurance Commissioners in December, 1958, and recommended for adoption in all states having a statutory fire policy. This enactment incorporates into the statute essentially the language of a policy endorsement issued with all fire policies in every state, including Massachusetts, with the formal approval of the insurance commissioners. This policy provision now specifically authorized by statute makes a loss not caused by fire, but by nuclear reaction, nuclear radiation or radioactive contamination, not compensable as a fire loss even though the reactor blast or the radiation or contamination diffusion resulted from a fire on the premises of the reactor or in the reactor. A right of recovery remains, however, for a loss caused by fire and not by the nuclear blast as, e.g., when a nuclear blast causes an actual fire on the premises of the reactor which spreads to an adjoining property and destroys it. The amendment to the uniform bill,[3] thought to be necessary in only one other state, is intended to give clearer expression to this latter result.

The possibility of loss or damage from nuclear energy hazards has for some years been a matter of considerable concern to the insurance companies and to the Federal Government. The insurance companies in a major effort to respond to the need for exceedingly high amounts of coverage have developed two insurance pools, that of the stock companies known as the Nuclear Energy Liability Insurance Association and that of the mutual companies known as the Mutual Atomic Energy Liability Underwriters. The Federal Government has adopted indem-

[2] Adding new Section 99A to G.L., c. 175.

[3] Before enactment the N.A.I.C. model bill was amended by the addition of the following language: "however, subject to the foregoing and all provisions of said policy, direct loss by fire resulting from nuclear reaction, or nuclear radiation or radioactive contamination is insured against by such policy."

nification legislation[4] to provide coverage beyond the capacity of the private insurers. Property owners whose property is damaged or destroyed by a nuclear blast or by radioactive contamination are now protected for such loss under the insurance afforded to the operator of a nuclear reactor. Such operators, licensed by the Atomic Energy Commission, have insurance up to $60 million from the insurance pools and, in addition, up to $500 million of Government indemnity. The Government indemnity also applies with respect to the operation of nuclear reactors by the Government. The liability for any such damage or destruction is regarded as absolute and is unaffected by the presence or absence of negligence on the part of the reactor operator. In these circumstances it is appropriate to exclude such damage or destruction from the coverage of policies issued to the property owners.

§16.11. Liability insurance: Joint tort-feasors. Acts of 1962, c. 730, adds to the General Laws a new chapter[1] dealing with the rights to contribution among joint tort-feasors. Prior to this enactment no right of contribution existed in Massachusetts if the person seeking contribution had himself been guilty of personal fault.[2] With respect to torts committed on or after January 1, 1963, a joint tort-feasor who has paid more than his pro rata share of the common liability may recover the excess over his pro rata share from the other joint tort-feasor or tort-feasors. Such recovery is limited to the excess payment, and no joint tort-feasor is compelled to contribute more than his pro rata share of the common liability. A liability insurer, who has paid on behalf of an insured joint tort-feasor the insured's obligation in full or in part and has thereby discharged its full obligation as insurer, is subrogated to the joint tort-feasor's right of contribution to the extent of any payment in excess of the tort-feasor's pro rata share of the common liability. This right of subrogation is in addition to any other subrogation rights of the insurer.

The new law preserves the established right of a joint tort-feasor without personal fault who has paid the injured party to indemnity from the person or persons who caused the injury.[3] It is specifically provided that such a person's right to indemnity is unimpaired and the person owing indemnity is not entitled to contribution from the indemnitee for any portion of his indemnity obligation. In determining the pro rata shares of tort-feasors in the entire liability their relative degrees of fault are not considered, but the principles of equity applicable to contribution generally apply.[4] An action to enforce contribution must be brought within one year after the judgment has become final.

Heretofore a release of one of two or more persons liable in tort for

4 Price-Anderson Act, 71 Stat. 576, 42 U.S.C. §2210 (1958), as amended through Pub. L. 87-206, 75 Stat. 479 (1961).

§16.11. 1 G.L., c. 231B. See §3.8 *supra*.
2 Churchill v. Holt, 131 Mass. 67 (1881).
3 Hollywood Barbecue Co. v. Morse, 314 Mass. 368, 50 N.E.2d 55 (1943).
4 Tait v. Downey, 267 Mass. 422, 166 N.E. 857 (1929).

the same injury released all.[5] Under the new statute a release of one tort-feasor does not discharge the others unless the release so provides. However, the claim against the others shall be reduced by the amount paid under the release, and the tort-feasor to whom the release is given will be discharged from all liability for contribution to any of the others.

§16.12. Liability insurance: Wrongful death. Acts of 1962, c. 306, amends the Wrongful Death Statute[1] to increase the minimum damage limits for wrongful death from $2000 to $3000 and the maximum damage limits from $20,000 to $30,000. These increased amounts apply only to actions for death resulting from injuries sustained or accidents occurring on or after January 1, 1963.[2]

§16.13. Accident and health insurance: Non-profit service plans. Two new chapters were added during the 1962 SURVEY year to the General Laws authorizing the formation of dental service corporations[1] and optometric service corporations.[2] Such corporations may be created to provide respectively dental and optometric services under the non-profit service plan whereby the cost of service to subscribers and covered dependents is paid by the corporation to participating dentists or optometrists. Each of the statutes follows essentially the provisions of the statute authorizing the medical service corporation[3] popularly called the Blue Shield. It is noteworthy that unlike the medical service corporation statute, the new statutes require prior approval by the Commissioner of Insurance of the subscription forms and of the rates charged to the subscribers.[4] It is also significant that these statutes refer throughout to "premiums" charged to subscribers, reflecting a recognition of the fact that the service plans have become increasingly more akin to insurance plans, losing much of the original concept of service plans. As with the medical service plans, the dental and optometric service plans must file their subscription agreements for approval and they may be disapproved by the Commissioner of Insurance if he finds that the services offered are unreasonable in relation to the premium charged, or if the premiums charged are excessive, inadequate or unfairly discriminatory. A new and additional test is established under the optometric service plans statute which requires disapproval if the services offered are unreasonable in relation to "economic practicality of providing for such prepaid services."[5] It will be interesting to see what meaning is given to these words and how this test may someday be applied in testing the approvability of a forms and rate filing.

[5] Matheson v. O'Kane, 211 Mass. 91, 97 N.E. 638 (1912).

§16.12. [1] G.L., c. 229, §2. See §3.6 *supra*.
[2] For discussion of this statute in the conflict of laws area, see §8.1 *supra*.

§16.13. [1] Acts of 1962, c. 714, adding G.L., c. 176E.
[2] Acts of 1962, c. 774, adding G.L., c. 176F.
[3] G.L., c. 176B.
[4] See §16.7 *supra*, note 2.
[5] G.L., c. 176F, §6.

§16.14. Accident and health insurance: Dependent's benefits. Acts of 1962, c. 634, amends the individual accident and sickness policy provisions law[1] and the group disability policy provisions law[2] to require such policies while in force to continue benefits for a dependent child beyond the age at which such dependent child's eligibility for benefits would otherwise terminate if the child is mentally or physically incapable of earning his own living. This additional coverage is conditioned upon submission to the insurer of proof of the dependent child's incapacity within thirty-one days of the attainment of the termination age specified by the policy and will continue so long as the incapacity continues.

§16.15. Health insurance: Mass 65. In several states, notably Massachusetts, Connecticut and New York, an effective device for making group health insurance benefits generally available to the elderly has been developed by the insurance companies operating as an association of joint underwriters. In each state a relatively generous grant of coverage is offered to residents of the state sixty-five years of age or older and to the spouses of such residents at premium rates which are supportable only if a large group of persons are insured without subjecting the insurers to serious adverse selection. Coverage may be obtained without medical examination provided application is made by those already eligible during a short, widely publicized and statewide enrollment period, and by those who subsequently become eligible within a brief period following the sixty-fifth birthday. Application for coverage and premium payments may be made either by the elderly person or by a member of his family, who may now or in the future bear the responsibility for care of the elderly person.

In each state legislation authorizing such joint underwriting by insurance companies was required. In Massachusetts, Acts of 1962, c. 392,[1] enables two or more companies authorized to transact a health insurance business, either jointly in their own names or in the name of a voluntary unincorporated association, to issue a policy of group insurance under which each company is severally liable for a specified percentage of the insured risks. The companies may fix premium rates and agree upon policy provisions, commission schedules and such other matters as are necessary to make possible a uniform offering. Policy forms, commission schedules and premium rates are required to be filed with the Commissioner of Insurance, who may after appropriate notice and hearing disapprove the policy forms if he finds them to be unjust, unfair, inequitable, misleading or deceptive, or the premium rates if he finds them to be excessive, inadequate or unfairly discriminatory. Both the Accident and Sickness Policy Provisions Law[2] and the Group Accident and Health Policy Law[3] are made in-

§16.14. [1] G.L., c. 175, §108, specifically paragraph (a) of subdivision 2.
[2] Id. §110, specifically subdivision D.

§16.15. [1] Adding new Section 110C to G.L., c. 175.
[2] G.L., c. 175, §108, discussed in 1958 Ann. Surv. Mass. Law §18.11.
[3] G.L., c. 175, §110.

applicable to such policy forms. Any agent or broker licensed to place health insurance may, without further licensing, solicit insurance for any association formed under the authority of this statute.

It seems possible that widespread use of this method of making privately underwritten group health insurance benefits available to persons who have reached or passed what has come to be regarded as the normal retirement age, who are as a consequence generally no longer eligible for benefits under established group insurance plans, and whose actual or potential state of health makes difficult the purchase of individual health insurance policies, will substantially reduce the need for government-sponsored and tax-supported medical care programs. Whether the ever-increasing volume of health insurance benefits being afforded by private insurance companies for all age groups, including the older age groups, will relieve the political pressure for such governmental programs remains to be seen. In the current political activity scant attention is being paid to the fact that the breadth of coverage, the competence of insurance specialists in the administration of insurance programs and the capacity to match protection to need which characterize privately underwritten insurance is not likely to be duplicated by any governmental agency.

§16.16. Motor vehicle insurance: Cancellation. Acts of 1962, c. 178,[1] restricts the right of appeal from the cancellation of a compulsory motor vehicle liability policy or bond to the Board of Appeal on Motor Vehicle Liability Policies or Bonds to exclude the cancellation for non-payment of premium of a policy insuring a motor vehicle registered as a taxicab or for public livery use.

§16.17. Policy forms: Departmental approval. Under the applicable provisions of the insurance law heretofore in effect no policy providing coverage against loss or damage caused by hazards specified in more than one of the kinds of insurance a company is authorized to write,[1] no policy of individual accident and sickness insurance,[2] no policy of life or endowment insurance or contract for the payment of an annuity or pure endowment,[3] no group life insurance policy[4] and no group annuity contract[5] could be issued until it had been on file with the Commissioner of Insurance for a period of thirty days unless within that period he approved the policy in writing. Neither could such a policy be issued if the commissioner notified the company in writing that in his opinion the policy did not comply with the laws of the Commonwealth. The statutes further specified that such disapproval action was subject to review by the Supreme Judicial Court.

§16.16. [1] Amending G.L., c. 175, §113D.

§16.17. [1] G.L., c. 175, §22A (regulating approval of combination policies) and §47 (defining the kinds of insurance which companies may be authorized to write).
[2] G.L., c. 175, §108.
[3] Id. §132.
[4] Id. §134.
[5] Id. §132B.

Acts of 1962, c. 426,[6] expands each of the existing approval sections and specifies in considerable detail the filing and approval procedure and the method of obtaining judicial review of a withdrawal of approval by the commissioner. Under the new provisions the commissioner may by written notice to the filing company extend for an additional thirty days the thirty-day period specified in the prior law. At expiration of the original filing period or any extension thereof the policy is deemed approved unless it has within the applicable period been affirmatively approved or disapproved. Affirmative approval will constitute a waiver of any unexpired portion of the applicable filing period.[7]

If a disapproved form of policy is resubmitted to the commissioner within thirty days of receipt of the notice of disapproval, such resubmitted form may not be issued until it has been on file for a period of thirty days unless within that period it is approved in writing, or if within that period it is disapproved in writing. At the expiration of such period the resubmitted form is deemed approved unless prior to the expiration of the period it has been affirmatively approved or disapproved.[8]

The commissioner may give written notice to the filing company of intent to withdraw approval of a form of policy previously affirmatively approved or deemed to have been approved and fixing a place and date of a hearing, which may not be less than twenty days from date of notice to the filing company. Following the required hearing the commissioner must give written notice to the filing company of any decision to withdraw approval, and after the expiration of thirty days following receipt of this notice it is unlawful for the company to issue the disapproved policy form. The filing company may, within twenty days following the filing of a memorandum thereof with the commissioner, petition the Supreme Judicial Court for a review of the action of the commissioner.[9] Unless otherwise directed by the Court the commissioner's order will remain in effect pending the final decision of the Court, which reviews all questions in accordance with the standards prescribed by the Administrative Procedure Act.[10]

§16.18. Mutual companies: Dividend classifications. As the American economy expands, as the volume of international trade increases, as the value and destructiveness of vehicles of travel and transport multiply, as nuclear energy and its application are further developed and as man moves deeper into the space age, the need and demand for more and more insurance at higher and higher limits grow apace. Many risks today require amounts of insurance which are beyond the capacity of a single insurance company to satisfy. Moreover, this insurance is required on hazard potentials which are increasingly diffi-

[6] Adding to G.L., c. 175, new Sections 193F, 193G and 193H.
[7] G.L., c. 175, §193F.
[8] Id. §193G.
[9] Id. §193H.
[10] Id., c. 30A, §14, cl. (8).

cult to define, more often than not cannot be measured on the basis of past experience and in some cases may even be unknown. To make such insurance available requires the collaborative efforts of multiple insurers.

Acts of 1962, c. 397, amends the section of the insurance law which regulates the dividend practices of mutual property and casualty companies.[1] By this amendment these companies are authorized to classify separately for dividend purposes policies insuring risks shared with other insurers and to pay a different rate of dividend from, but not in excess of, the rate of dividend which would otherwise be payable if the policies were not separately classified. This separate classification may be applied to policies covering (1) credit risks arising from foreign trade, (2) loss of or damage to aircraft, missiles or spacecraft, (3) liability arising out of the ownership, maintenance or use of aircraft, missiles or spacecraft, (4) products liability on aircraft, missiles or spacecraft, and (5) other extrahazardous risks arising out of the manufacture or development for national defense of products which involve potential catastrophic losses and which cannot be evaluated by prior experience. No such separate classification may include coverage for liability under any workmen's compensation or occupational disease law.

§16.19. Insurance companies. Acts of 1962, c. 179, further modifies the Administrative Procedure Act[1] to exempt from the hearing requirements of the act a refusal by the Commissioner of Insurance to renew the license of a foreign insurance company upon the grounds of insolvency, capital stock or guaranty fund impairment, or contingent assets or surplus deficiency. An earlier amendment had exempted from the requirement of hearing the revocation of such a license.[2]

Acts of 1962, c. 57, amends the statutory provision to require the calling of a special meeting of the members of a mutual property or casualty company upon the written request of at least .5 percent of the members.[3] Heretofore such a request by twenty members sufficed to obtain the call of a special meeting.

§16.18. [1] G.L., c. 175, §80.

§16.19. [1] G.L., c. 30A, §13, added by Acts of 1954, c. 681, §1.
[2] Acts of 1960, c. 245, noted in 1960 Ann. Surv. Mass. Law §16.14.
[3] Amending G.L., c. 175, §77.